



SERVICE DELIVERY DOCUMENTATION

OSSAS Provider Training
April 28, 2022



Type your Questions
in the chat



We will compile all questions and
answers and send them to
attendees within the next two
weeks



Slides are in the Handouts section
and will also be sent out after the
training

QUESTIONS?

OTHER REQUIREMENTS

This training goes over the service delivery documentation requirements as of April 28, 2022

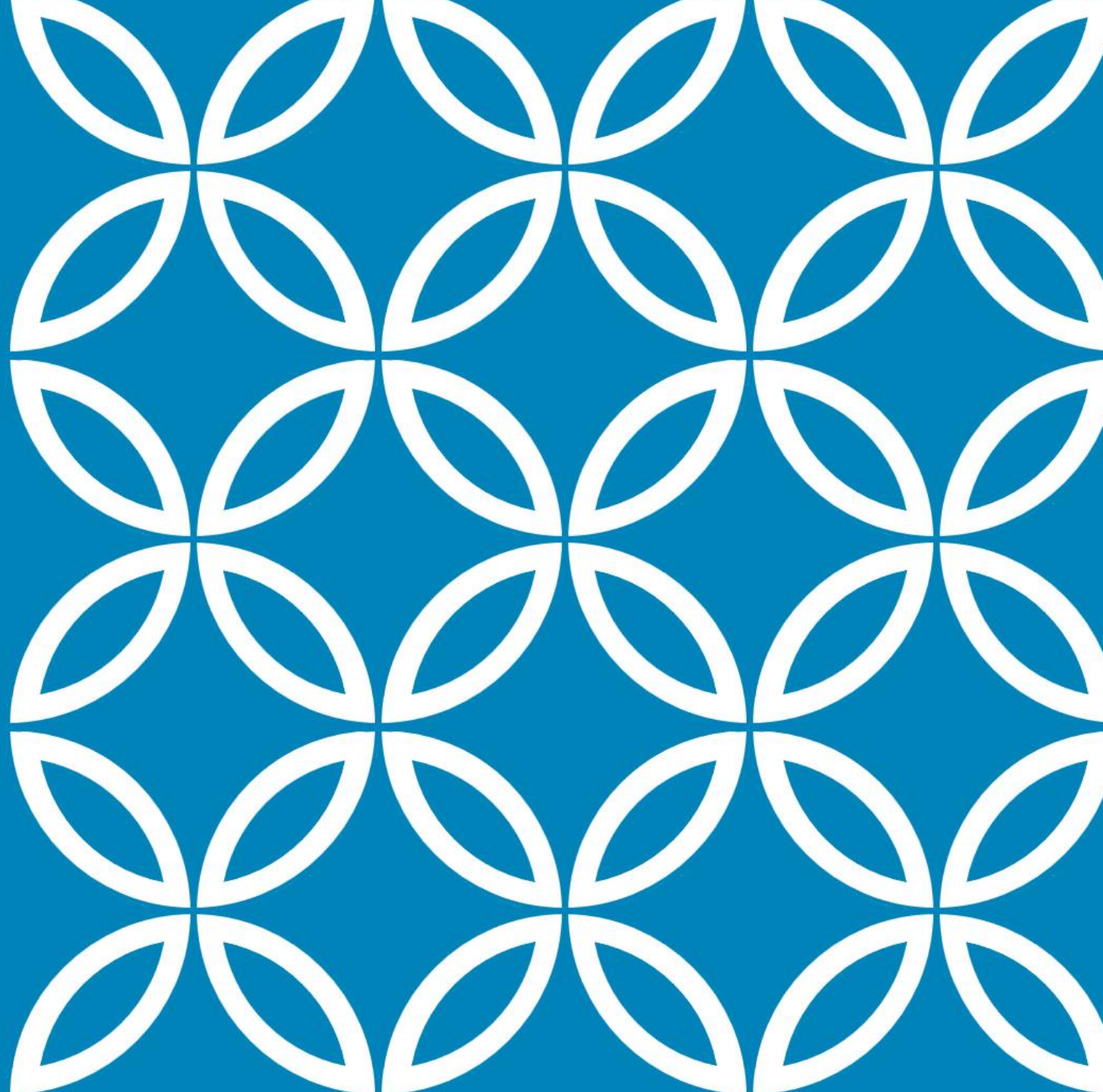
This is not an all-inclusive list of all types of documentation a provider is responsible for having/maintaining

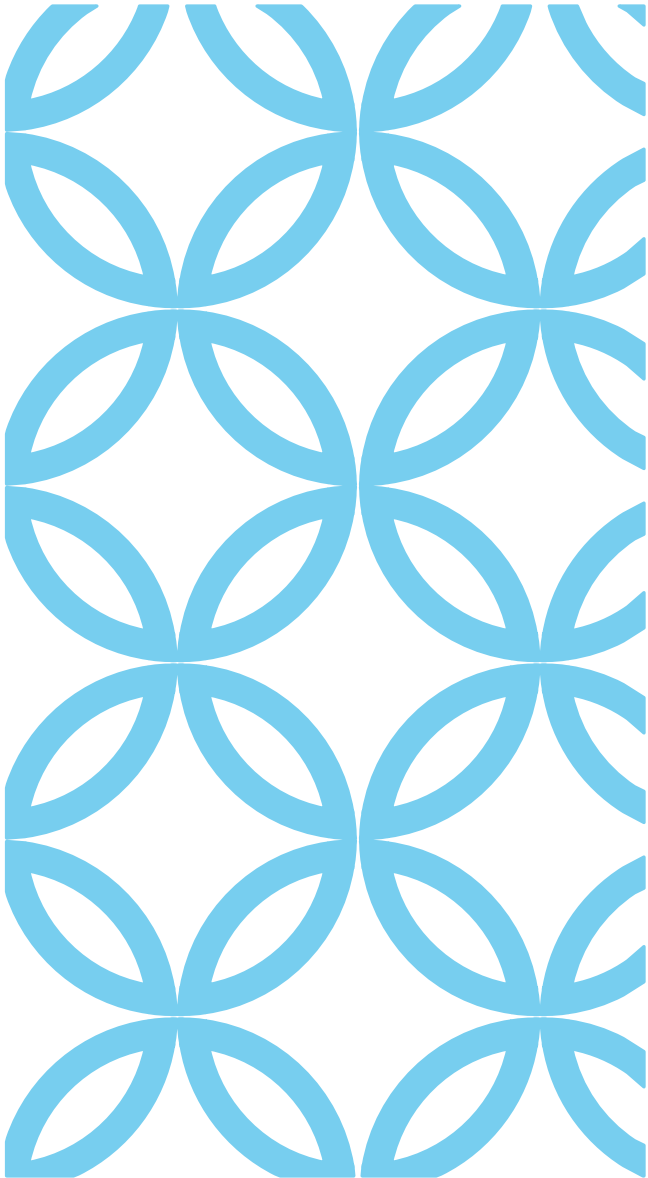
Providers are responsible for knowing and being compliant with all applicable requirements and keeping up to date on changes in requirements

WHAT IS SERVICE DOCUMENTATION?

All records and information

- On one or more documents, including documents that may be created or maintained in electronic software programs
- Created and maintained contemporaneously with the delivery of services
- And kept in a manner as to fully disclose the nature and extent of services delivered
- That shall include items delineated in service-specific rules in Chapters 5123-9 and 5123:2-9 of the Administrative Code to validate payment for Medicaid services



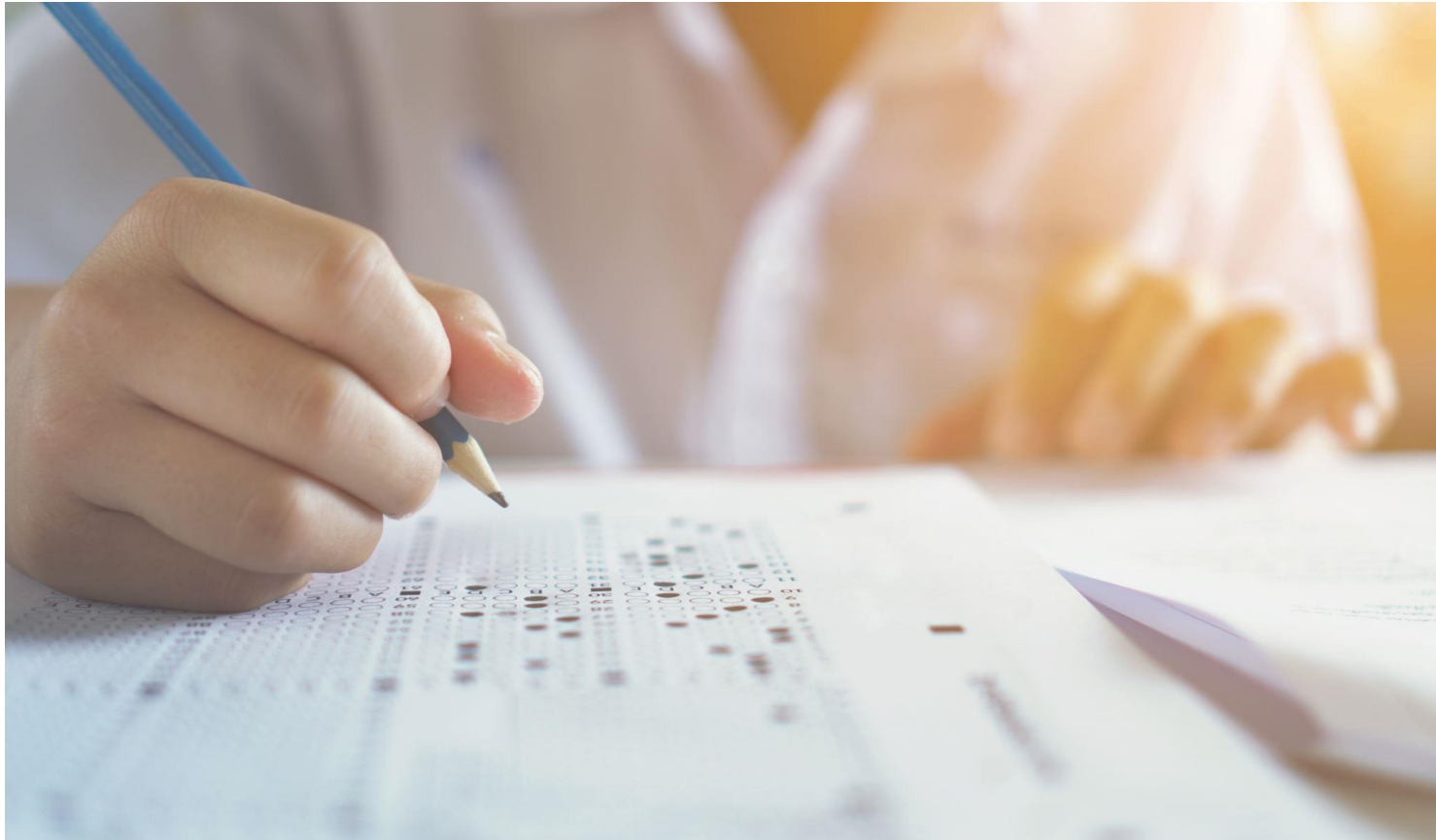


All Providers

- Shared Living
- NMT only
- HPC
- Adult Day Services providers
- Ancillary Service providers

If you provided a waiver service, you must have service documentation for it

WHO MUST KEEP SERVICE DOCUMENTATION?



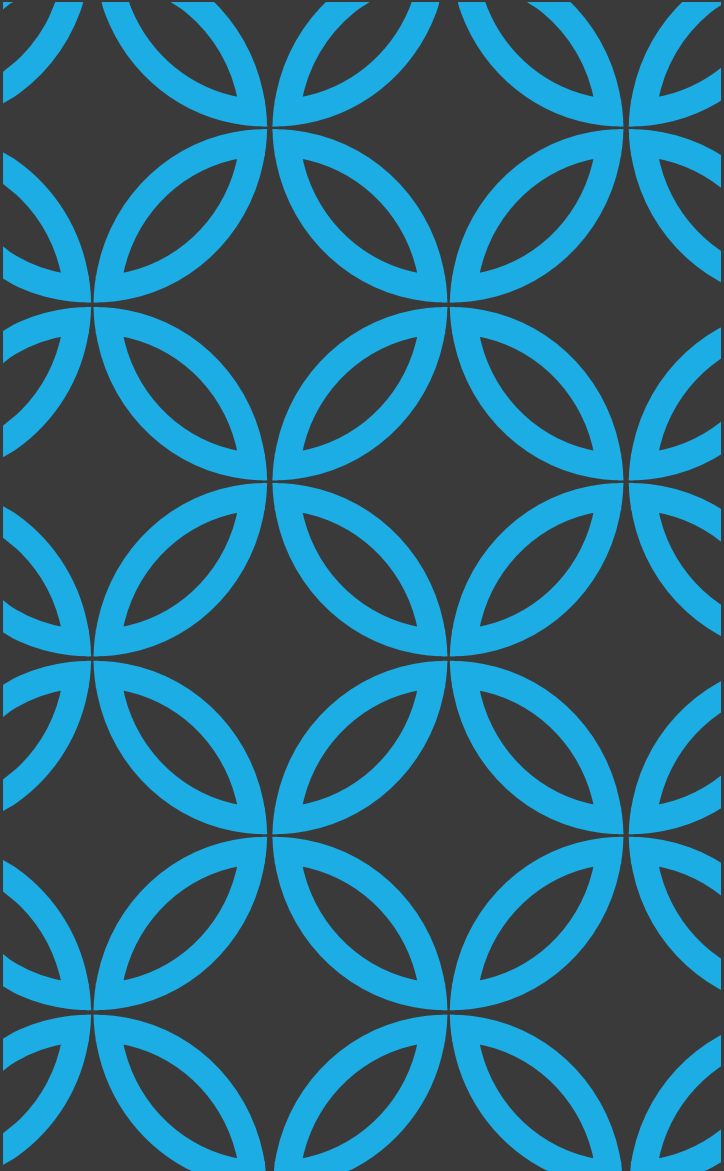
WHY KEEP DOCUMENTATION?

- Validate Payment
- Provide evidence of what you did

If it isn't documented, it didn't happen

HOW LONG DO PROVIDERS HAVE TO KEEP DOCUMENTATION?

Records necessary to disclose fully the extent of the services provided must be kept for a period of six years from the date of receipt of payment or, if an audit has been initiated, until the audit is resolved, whichever is longer



SERVICE DOCUMENTATION VS BILLING DOCUMENTATION

- Claims for payment a provider submits to the department for services delivered shall not be considered service documentation
- Any information contained in the submitted claim for payment may not and shall not be substituted for any required service documentation that a provider is required to maintain to validate payment for Medicaid services

CONFIDENTIALITY

Agency providers must have a written policy and procedure addressing their management practices regarding confidentiality of individuals' records

Service documentation is to be maintained in an accessible location

Documentation shall be made available upon request for review by:

- DODD
- ODM
- CMS
- CB/COG that submits payment authorization for the service to the department
- Those designated or assigned authority by the Department or ODM to review service documentation

ELECTRONIC DOCUMENTATION

- Electronic documentation systems/signatures should be secured in a manner that ensures no one else can 'sign' on behalf of another person
- Still needs to include all required elements

- Employment First documentation
- Personal funds
- UI/MUI
- Behavior support
- Background Check & Training documentation
- Policies and Procedures
- Medication Administration documentation
- Coordination of medical care documentation
- Outcomes Documentation
- Lease/Residency Agreement
- Vehicle Inspections



OTHER TYPES OF REQUIRED DOCUMENTATION

DISCONTINUATION OF SERVICES

Written notice to the individual and the individual's SSA is required in the event the provider intends to cease providing services

- Shall be provided **no less than thirty calendar days** prior to termination of services

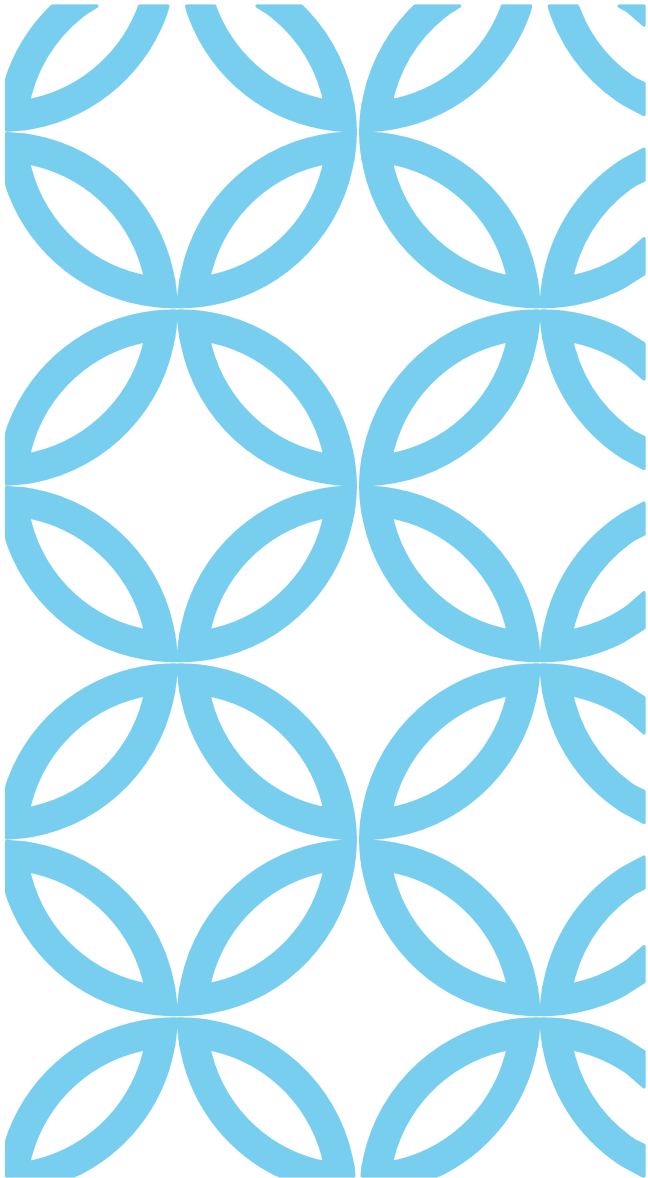
When a provider discontinues operations, the provider shall, within seven calendar days, notify the county boards for the counties in which individuals for whom the provider has provided services reside, of the location where the service documentation will be stored, and provide the county board with the name and telephone number of the person responsible for maintaining the service documentation

HOW DO I FIND MY SERVICE SPECIFIC DOCUMENTATION REQUIREMENTS?

All DODD rules can be found at
<https://dodd.ohio.gov/forms-and-rules/rules-in-effect/administrative-rules-list>

- Go to dodd.ohio.gov, click on Rules & Forms, then Rules in Effect to get to the same place

Within each service specific rule, there is a section titled 'Documentation of Services' that outlines what needs to be included on the service delivery documentation for that service



- Name of individual receiving service
- Medicaid ID number of individual receiving the service
- Name of provider
- Provider identifier/contract number
- Type of Service***

SERVICE DOCUMENTATION REQUIREMENTS — ALL SERVICES BUT PARTICIPANT DIRECTED GOODS & SERVICES



Assistive Technology –
specify consultation,
equipment, or
support

NMT – Specify
type of NMT (per-
trip or per-mile)

Community Respite –
Specify community
respite full day billing
unit, community respite
partial day billing unit,
or community respite
fifteen-minute billing unit

Waiver Nursing
Delegation - Specify
waiver nursing
delegation/ assessment
or waiver nursing
delegation/ consultation

CAVEATS ON TYPE OF SERVICE

For Self-Directed Transportation provided by vendors of ground transportation available to the general public

- Type of service is the Mode of self-directed transportation for which voucher, card, pass, or token may be used (e.g., bus, light rail transit, livery vehicle, or ride-hailing service) provided

For Self-Directed Transportation via per-mile or per-trip reimbursement made to a person who meets the provider qualifications in paragraph (C) of this rule and who has a written agreement for provision of self-directed transportation with the individual being transported:

- Type of service is the Type of motor vehicle used to provide self-directed transportation (i.e., modified vehicle or non-modified vehicle)

TYPE OF SERVICE FOR SELF-DIRECTED TRANSPORTATION



ALL SERVICES BUT ASSISTIVE TECH AND PARTICIPANT DIRECTED GOODS & SERVICES

- Date of Service***
- Place of Service***
- Written or electronic signature of the person delivering the service, or initials of the person delivering the service if a signature and corresponding initials are on file with the provider ***
- Description and details of the services delivered that directly relate to the services specified in the approved ISP as the services to be provided

STIPULATIONS

The Emergency Assistance services requires all documentation elements of the underlying service

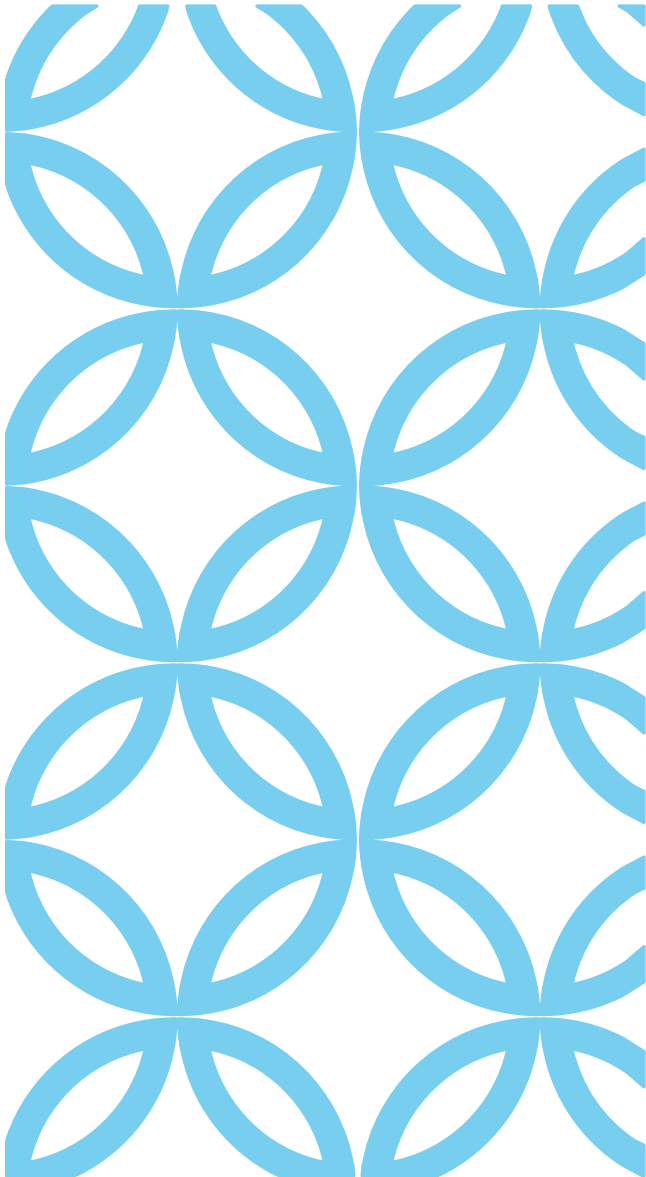
NMT and HPC transportation: Place of service is the 'license plate number of the vehicle used to provide the service

NMT - Signature specifically needs to come from the driver

Waiver Nursing - Description and details must also include the individual's response to each medication, treatment, or procedure performed in accordance with the physician's orders or plan of care

Community Respite - Date and time of the individual's arrival at and departure from the community respite service delivery location

Community Transition – location of services not required



For Self-Directed Transportation provided by vendors of ground transportation available to the general public:

- Date of Service is the date of purchase of voucher, card, pass, or token
- Written signature of the person delivering the service is not required for this type of Self-Directed Transportation

For all types of Self-Directed Transportation:

- Place of Service is not required
- Description and details of the services delivered that directly relate to the services specified in the approved ISP as the services to be provided is NOT required

STIPULATIONS CONTINUED

GROUP SIZE IN WHICH THE SERVICE WAS PROVIDED

- Nutrition Services
- HPC (if not billed at daily rate)
- Participant Directed HPC
- Shared Living
- Remote Support
- Interpreter Services
- Social Work
- Waiver Nursing
- Transportation***
- Non-Medical Transportation***
- Self-Directed Transportation ***

*** - SEE NEXT SLIDE

REQUIREMENTS VERIFIED 08.01.22

STIPULATIONS FOR GROUP SIZE DOCUMENTATION

Transportation

- Number of individuals being transported

Non-Medical Transportation

- Names of all passengers, including paid staff and volunteers, who were in the vehicle during any portion of the trip and/or commute

Self-Directed Transportation via per-mile or per trip reimbursement

- Number of individuals being transported

TIMES THE DELIVERED SERVICE STARTED AND STOPPED

- Career Planning - career exploration, job development, self-employment launch, and worksite accessibility components
- Vocational Habilitation
- Individual Employment Support
- Group Employment Support
- Adult Day Support
- Non-Medical Transportation
- Money Management
- Informal Respite
- Community Respite***
- Nutrition Services
- Home-Delivered Meals
- HPC (if not billed at daily rate)
- Participant Directed HPC
- Remote Support***
- Interpreter Services
- Waiver Nursing Delegation
- Social Work
- Waiver Nursing
- Clinical/Therapeutic Intervention
- Participant/family stability assistance
- Support Brokerage

*** - SEE NEXT SLIDE

REQUIREMENTS VERIFIED 08.01.22



CLARIFICATION ON START AND STOP TIMES

- Community Respite - Date and time of the individual's arrival at and departure from the community respite service delivery location
- Remote Support – begin and end time of the remote support service when the backup support person is needed on site

NUMBER OF UNITS OF THE DELIVERED SERVICE

THESE SERVICES SPECIFICALLY REQUIRE THE NUMBER OF UNITS. OTHER SERVICES ALLOW FOR AN ALTERNATIVE.

- Career Planning - career exploration, job development, self-employment launch, and worksite accessibility components
- Vocational Habilitation
- Individual Employment Support
- Group Employment Support
- Adult Day Support
- Non-Medical Transportation — Per Mile***
- Transportation***
- Nutrition Services
- Home-Delivered Meals***
- Remote Support***
- Interpreter Services
- Social Work

*** - SEE NEXT SLIDE

REQUIREMENTS VERIFIED 08.01.22

SPECIFICS REGARDING NUMBER OF UNITS



Home-Delivered Meals – Number of meals delivered



Remote Support – number of units of the delivered service per calendar day



NMT – Per Mile - For per-mile rate, number of miles in each distinct commute, as indicated by recording beginning and ending odometer readings or via tracking or mapping by a GPS



Transportation - Total Number of miles of transportation provided



Self-Directed Transportation at per-trip or per-mile reimbursement – Total Number of miles of self-directed transportation provided

NUMBER OF UNITS
OR
THE CONTINUOUS
AMOUNT OF
UNINTERRUPTED
TIME DURING
WHICH THE SERVICE
WAS PROVIDED

Money Management

HPC (if not billed at daily rate)

Participant Directed HPC

Waiver Nursing Delegation

Waiver Nursing

Clinical/Therapeutic Intervention

Participant/Family Stability Assistance

Support Brokerage

OTHER REQUIRED DOCUMENTATION ITEMS

HPC Transportation -
Origination and destination
points of transportation
provided

Home-Delivered Meals –
Name of person accepting
delivery of meals

Assistive Technology –
additional requirements
outlined in rule for each
individual component of
assistive tech (Consultation,
Equipment, & Support)

Self-Directed Transportation
at the per-trip or per-mile
reimbursement – Origination
and destination points of self-
directed transportation
provided

PDHPC - Common law
employee shall prepare an
accurate timesheet to be
verified by the individual
receiving PDHPC prior to
submission to the financial
management services entity

Home-Delivered Meals – Type
of meals provided (i.e.,
kosher, therapeutic, or
standard)

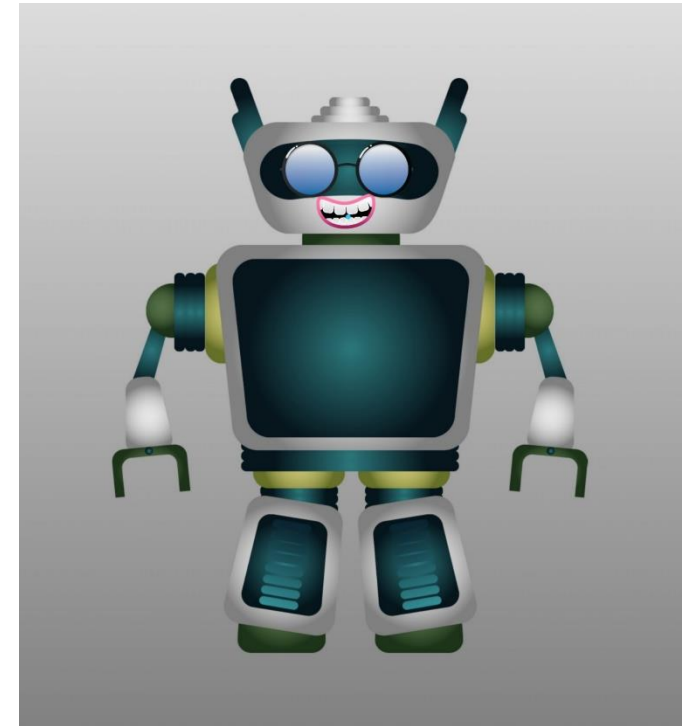
Self-Directed Transportation
provided by vendors of
ground transportation
available to the general
public – Receipt indicating
amount paid

OTHER REQUIRED DOCUMENTATION ITEMS CONT'D

- Waiver Nursing Delegation - Additional requirements outlined in rule for waiver nursing delegation/assessment (5123-2-9-37 (E)(2) and waiver nursing delegation/consultation 5123-2-9-37 (E)(3)
- Waiver Nursing – Additional documentation requirements outlined in rule regarding clinical record 5123-9-39 (F)(2)
- Participant Directed Goods & Services - Written invoice that contains the individual's name and Medicaid identification number, a description of the item or service provided, the provider's name, the date the item or service was provided, and the provider's charge for the item or services
- Community Transition - Detailed description of each expense AND a receipt for each expense with the individual's signature, mark, stamp or other method identified in the ISP to verify his or her receipt of the purchased item or service

ASSISTIVE TECHNOLOGY 5123-9-12

- Type of service – (i.e., assistive technology consultation, assistive technology equipment, or assistive technology support)
- Name of Individual
- Medicaid Number
- Name of Provider
- Provider Identifier/contract number
- Additional requirements for each individual component of assistive technology***



ADDITIONAL REQUIREMENTS — ASSISTIVE TECH

- Assistive technology consultation shall also include:
 - A description of the functional evaluation process and technologies considered to address the individual's needs and support desired outcomes
 - A written recommendation that identifies the specific items and estimated cost of assistive technology equipment necessary to advance achievement of outcomes defined in the individual service plan
 - The date the written recommendation was completed and submitted to the individual's service and support administrator
- Assistive technology equipment shall also include:
 - The address where assistive technology equipment is installed
 - A list of installed assistive technology equipment including the date each item of assistive technology equipment is installed, modified, repaired, or removed and the reasons therefore, and associated adjustments in cost
- Assistive Technology Support shall also include:
 - The date, time, duration, location, and description of education and training provided and the names of persons receiving the education and training
 - The date, time, duration, location, and description of activities necessary to coordinate assistive technology with complementary therapies or interventions



**CAREER PLANNING — 5123-9-13
CAREER EXPLORATION, JOB DEVELOPMENT, SELF-
EMPLOYMENT LAUNCH, AND WORKSITE
ACCESSIBILITY COMPONENTS OF CAREER PLANNING**

- Type of service
- Date of service
- Place of service
- Name of individual receiving service
- Medicaid identification number of individual receiving service
- Name of provider
- Provider identifier/contract number
- Written or electronic signature of the person delivering the service, or initials of the person delivering the service if a signature and corresponding initials are on file with the provider
- Description and details of the services delivered that directly relate to the services specified in the approved individual service plan as the services to be provided
- Times the delivered service started and stopped
- Number of units of the delivered service

CAREER PLANNING – 5123-9-13

BENEFITS EDUCATION AND ANALYSIS, CAREER DISCOVERY, EMPLOYMENT/SELF-EMPLOYMENT PLAN, AND SITUATIONAL OBSERVATION AND ASSESSMENT COMPONENTS OF CAREER PLANNING

- Type of service
- Date of service
- Place of service
- Name of individual receiving service
- Medicaid identification number of individual receiving service
- Name of provider
- Provider identifier/contract number
- Written or electronic signature of the person delivering the service, or initials of the person delivering the service if a signature and corresponding initials are on file with the provider
- Description and details of the services delivered that directly relate to the services specified in the approved individual service plan as the services to be provided. The description and details of the services delivered shall be sufficient to demonstrate achievement of the desired outcomes in order to serve as the report required for payment for delivery of the services

VOCATIONAL HABILITATION — 5123-9-14

- Type of service.
- Date of service
- Place of service
- Name of individual receiving service
- Medicaid identification number of individual receiving service
- Name of provider
- Provider identifier/contract number
- Written or electronic signature of the person delivering the service, or initials of the person delivering the service if a signature and corresponding initials are on file with the provider
- Description and details of the services delivered that directly relate to the services specified in the approved individual service plan as the services to be provided
- Times the delivered service started and stopped
- Number of units of the delivered service.

INDIVIDUAL EMPLOYMENT SUPPORT — 5123-9-15

- Type of service
- Date of service
- Place of service
- Name of individual receiving service
- Medicaid identification number of individual receiving service
- Name of provider
- Provider identifier/contract number
- Written or electronic signature of the person delivering the service, or initials of the person delivering the service if a signature and corresponding initials are on file with the provider
- Description and details of the services delivered that directly relate to the services specified in the approved individual service plan as the services to be provided
- Times the delivered service started and stopped
- Number of units of the delivered service

GROUP EMPLOYMENT SUPPORT — 5123-9-16

- Type of service
- Date of service
- Place of service
- Name of individual receiving service.
- Medicaid identification number of individual receiving service
- Name of provider
- Provider identifier/contract number
- Written or electronic signature of the person delivering the service, or initials of the person delivering the service if a signature and corresponding initials are on file with the provider
- Description and details of the services delivered that directly relate to the services specified in the approved individual service plan as the services to be provided
- Times the delivered service started and stopped
- Number of units of the delivered service

ADULT DAY SUPPORT — 5123-9-17

- Type of service
- Date of service
- Place of service
- Name of individual receiving service
- Medicaid identification number of individual receiving service
- Name of provider
- Provider identifier/contract number
- Written or electronic signature of the person delivering the service, or initials of the person delivering the service if a signature and corresponding initials are on file with the provider
- Description and details of the services delivered that directly relate to the services specified in the approved individual service plan as the services to be provided
- Times the delivered service started and stopped
- Number of units of the delivered service

NON-MEDICAL TRANSPORTATION

— 5123-9-18

- Type of non-medical transportation service (i.e., per-trip or per-mile) provided
- Date of service
- License plate number of vehicle used to provide service
- Name of individual receiving service
- Medicaid identification number of individual receiving service
- Name of provider
- Provider identifier/contract number
- Signature of driver of the vehicle or initials of driver of the vehicle if the signature and corresponding initials are on file with the provider
- Names of all passengers, including paid staff and volunteers, who were in the vehicle during any portion of the trip and/or commute
- Times the trip or commute started and stopped
- Service documentation for non-medical transportation at the per-mile rate also must include:
 - The number of miles in each distinct commute, as indicated by recording beginning and ending odometer readings or via tracking or mapping by a global positioning system



MONEY MANAGEMENT — 5123-9-20

- Type of service
 - Date of service
 - Place of service
 - Name of individual receiving service
 - Medicaid identification number of individual receiving service
 - Name of provider
 - Provider identifier/contract number
 - Written or electronic signature of the person delivering the service or initials of the person delivering the service if a signature and corresponding initials are on file with the provider
 - Description and details of the services
- delivered that directly relate to the services specified in the approved individual service plan as the services to be provided
- Number of units of the delivered service or continuous amount of uninterrupted time during which the service was provided
 - Times the delivered service started and stopped

INFORMAL RESPITE — 5123-9-21

- Type of service
- Date of service
- Place of service
- Name of individual receiving service
- Medicaid identification number of individual receiving service
- Name of provider
- Provider identifier/contract number
- Times the delivered service started and stopped
- Written or electronic signature of the person delivering the service
- Description and details of the services delivered that directly relate to the services specified in the approved individual service plan as the services to be provided

COMMUNITY RESPITE — 5123-9-22

- Type of service (i.e., community respite full day billing unit, community respite partial day billing unit, or community respite fifteen-minute billing unit)
- Date of service
- Place of service
- Name of individual receiving service
- Medicaid identification number of individual receiving service
- Name of provider
- Provider identifier/contract number
- Date and time of the individual's arrival at and departure from the community respite service delivery location
- Written or electronic signature of the person delivering the service, or initials of the person delivering the service if a signature and corresponding initials are on file with the provider
- Description and details of the services delivered that directly relate to the services specified in the approved individual service plan as the services to be provided

ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS — 5123-9-23

- Type of service
- Date of service
- Place of service
- Name of individual receiving service
- Medicaid identification number of individual receiving service
- Name of provider
- Provider identifier/contract number
- Written or electronic signature of the person delivering the service, or initials of the person delivering the service if a signature and corresponding initials are on file with the provider
- Description and details of the services delivered that directly relate to the services specified in the approved individual service plan as the services to be provided

TRANSPORTATION — 5123-9-24

- Type of service
- Date of service
- License plate number of vehicle used to provide service
- Name of individual receiving service
- Medicaid identification number of individual receiving service
- Name of provider
- Provider identifier/contract number
- Origination and destination points of transportation provided
- Total number of miles of transportation provided
- Number of individuals being transported
- Written or electronic signature of the person delivering the service, or initials of the person delivering the service if a signature and corresponding initials are on file with the provider
- Description and details of the services delivered that directly relate to the services specified in the approved individual service plan as the services to be provided



SPECIALIZED MEDICAL EQUIPMENT & SUPPLIES 5123-9-25

- Type of service
- Date of service
- Place of service
- Name of individual receiving service
- Medicaid identification number of individual receiving service
- Name of provider
- Provider identifier/contract number
- Written or electronic signature of the person delivering the service, or initials of the person delivering the service if a signature and corresponding initials are on file with the provider
- Description and details of the services delivered that directly relate to the services specified in the approved individual service plan as the services to be provided

SELF-DIRECTED TRANSPORTATION 5123-9-26

BY VENDORS OF GROUND TRANSPORTATION AVAILABLE TO THE GENERAL PUBLIC

- Mode of self-directed transportation for which voucher, card, pass, or token may be used (e.g., bus, light rail transit, livery vehicle, or ride-hailing service) provided
- Date of purchase of voucher, card, pass, or token
- Name of individual receiving service
- Medicaid identification number of individual receiving service
- Name of provider
- Provider identifier number or provider contract number
- Receipt indicating the amount paid

SELF-DIRECTED TRANSPORTATION 5123-9-26

FOR SELF-DIRECTED TRANSPORTATION VIA PER-MILE OR PER-TRIP REIMBURSEMENT MADE TO A PERSON WHO MEETS THE PROVIDER QUALIFICATIONS IN PARAGRAPH (C) OF THIS RULE AND WHO HAS A WRITTEN AGREEMENT FOR PROVISION OF SELF-DIRECTED TRANSPORTATION WITH THE INDIVIDUAL BEING TRANSPORTED

- Type of motor vehicle used to provide self-directed transportation (i.e., modified vehicle or non-modified vehicle)
- Date of service
- Name of individual receiving service
- Medicaid identification number of individual receiving service
- Name of provider
- Provider identifier number or provider contract number
- Origination and destination points of self-directed transportation provided
- Total number of miles of self-directed transportation provided
- Number of individuals being transported
- Written or electronic signature of the person delivering the service, or initials of the person delivering the service if a signature and corresponding initials are on file with the financial management services entity

EMERGENCY ASSISTANCE — 5123-9-27

- Emergency assistance means an increased amount of assistive technology, environmental accessibility adaptations, homemaker/personal care, informal respite, participant-directed homemaker/personal care, remote support, residential respite, specialized medical equipment and supplies, or transportation necessary to support an individual in an emergency.
- Documentation requirements are the same as the underlying service's requirements



NUTRITION SERVICES — 5123:2-9-28

- Type of service
- Date of service
- Place of service
- Name of individual receiving service
- Medicaid identification number of individual receiving service
- Name of provider
- Provider identifier/contract number
- Written or electronic signature of the person delivering the service, or initials of the person delivering the service if a signature and corresponding initials are on file with the provider
- Group size in which the service was provided
- Description and details of the services delivered that directly relate to the services specified in the approved individual service plan as the services to be provided
- Number of units of the delivered service
- Times the delivered service started and stopped



HOME-DELIVERED MEALS — 5123-9-29

- Type of service
- Type of meals provided (i.e., kosher, therapeutic, or standard)
- Date of service
- Place of service
- Name of individual receiving service
- Medicaid identification number of individual receiving service
- Name of provider
- Provider identifier/contract number
- Written or electronic signature of the person delivering the service, or initials of the person delivering the service if a signature and corresponding initials are on file with the provider
- Description and details of the services delivered that directly relate to the services specified in the approved individual service plan as the services to be provided
- Number of meals delivered
- Time that meals were delivered
- Name of person accepting delivery of meals

HOMEMAKER/PERSONAL CARE 5123-9-30

- Type of service
- Date of service
- Place of service
- Name of individual receiving service
- Medicaid identification number of individual receiving service
- Name of provider
- Provider identifier/contract number
- Written or electronic signature of the person delivering the service or initials of the person delivering the service if a signature and corresponding initials are on file with the provider
- Group size in which the service was provided
- Description and details of the services delivered that directly relate to the services specified in the approved individual service plan as the services to be provided
- Number of units of the delivered service or continuous amount of uninterrupted time during which the service was provided
- Times the delivered service started and stopped

HPC DAILY BILLING UNIT FOR SITES WHERE INDIVIDUALS ENROLLED IN THE I/O WAIVER SHARE SERVICES 5123-9-31

- Type of service
- Date of service
- Place of service
- Names of individuals
- Description and details of the services delivered that directly relate to the services specified in the approved individual service plan as the services to be provided
- Medicaid identification number of the individuals receiving services
- Name of provider
- Provider identifier/contract number
- Written or electronic signature of the person delivering the service or initials of the person delivering the service if a signature and corresponding initials are on file with the provider

PARTICIPANT DIRECTED HPC — 5123-9-32

- Type of service
- Date of service
- Place of service
- Name of individual receiving service
- Medicaid identification number of individual receiving service
- Name of provider
- Provider identifier/contract number
- Written or electronic signature of the person delivering the service
- Group size in which the service was provided
- Description and details of the services delivered that directly relate to the services specified in the approved individual service plan as the services to be provided
- Number of units of the delivered service or continuous amount of uninterrupted time during which the service was provided
- Times the delivered service started and stopped.
- A common law employee shall prepare an accurate timesheet to be verified by the individual receiving participant-directed homemaker/personal care prior to submission to the financial management services entity

DOCUMENTATION FOR INDEPENDENT PROVIDERS PROVIDING PARTICIPANT DIRECTED HPC

- Documentation is submitted to Morning Sun, who is the financial management service provider (FMS)
- Morning Sun requires these providers use a specific documentation sheet called the 'Timesheet & Task Detail Sheet'
 - This is not considered 'billing documentation' and is acceptable to use as part of your service delivery documentation
 - This sheet does not contain all required elements
- To ensure compliance:
 - Make sure you are using the current Timesheet & Task Detail Sheet (dated 12/28/20)
 - If you provide services anywhere other than the individual's home, you must document that location
 - The individual's Medicaid Number needs included on your documentation – this may be on a coversheet you keep in your documentation file
 - This service documentation requirements allow for number of units of the delivered service OR continuous amount of uninterrupted time during which the service was provided. As long as you complete the start and end times on the sheet, you meet this requirement.

SHARED LIVING — 5123-9-33

- Type of service
- Date of service
- Place of service
- Name of individual receiving service
- Medicaid identification number of individual receiving service
- Name of provider
- Provider identifier/contract number
- Written or electronic signature of the person delivering the service, or initials of the person delivering the service if a signature and corresponding initials are on file with the provider
- Group size in which the service was provided
- Description and details of the services delivered that directly relate to the services specified in the approved individual service plan as the services to be provided

RESIDENTIAL RESPITE — 5123-9-34

- Type of service
- Date of service
- Place of service
- Name of individual receiving service
- Medicaid identification number of individual receiving service
- Name of provider
- Provider identifier/contract number
- Written or electronic signature of the person delivering the service, or initials of the person delivering the service if a signature and corresponding initials are on file with the provider
- Description and details of the services delivered that directly relate to the services specified in the approved individual service plan as the services to be provided

REMOTE SUPPORT — 5123-9-35

- Type of service
- Date of service
- Place of service
- Name of individual receiving service
- Medicaid identification number of individual receiving service
- Name of provider
- Provider identifier/contract number.
- Begin and end time of the remote support service when the backup support person is needed on site
- Written or electronic signature of the person delivering the service, or initials of the person delivering the service if a signature and corresponding initials are on file with the provider
- Number of units of the delivered service per calendar day
- Group size in which the service was provided
- Description and details of the services delivered that directly relate to the services specified in the approved individual service plan as the services to be provided

INTERPRETER SERVICES — 5123:2-9-36

- Type of service
- Date of service
- Place of service
- Name of individual receiving service
- Medicaid identification number of individual receiving service
- Name of provider
- Provider identifier/contract number
- Written or electronic signature of the person delivering the service, or initials of the person delivering the service if a signature and corresponding initials are on file with the provider
- Group size in which the service was provided
- Description and details of the services delivered that directly relate to the services specified in the approved individual service plan as the services to be provided
- Number of units of the delivered service
- Times the delivered service started and stopped

WAIVER NURSING DELEGATION — 5123:2-9-37

- Type of service (i.e., waiver nursing delegation/assessment or waiver nursing delegation/consultation)
- Date of service
- Place of service
- Name of individual receiving service
- Medicaid identification number of individual receiving service
- Name of provider
- Provider identifier/contract number
- Written or electronic signature of the person delivering the service or initials of the person delivering the service if a signature and corresponding initials are on file with the provider
- Description and details of the service delivered that directly relate to the services specified in the approved individual service plan as the services to be provided, including the name of the unlicensed person for whom a supervisory visit was performed
- Number of units of the delivered service or continuous amount of uninterrupted time during which the service was provided
- Beginning and ending times of the delivered service

ADDITIONAL REQUIREMENTS — WAIVER NURSING DELEGATION

- In addition to service documentation specified in paragraph (E)(1) of this rule, service documentation for waiver nursing delegation/assessment shall include
 - the precipitating factor indicating why an assessment was needed, that is
 - The individual was discharged from hospital
 - The individual has experienced a significant change
 - Initiation of waiver nursing delegation for an individual who has not previously received waiver nursing delegation
- In addition to service documentation specified in paragraph (E)(1) of this rule, service documentation for waiver nursing delegation/consultation shall include a description and details of the consultation purpose and outcomes, including the name of the person with whom the delegating nurse was consulting

SOCIAL WORK — 5123:2-9-38

- Type of service
- Date of service
- Place of service
- Name of individual receiving service
- Medicaid identification number of individual receiving service
- Name of provider
- Provider identifier/contract number
- Written or electronic signature of the person delivering the service or initials of the person delivering the service if a signature and corresponding initials are on file with the provider
- Group size in which the service was provided
- Description and details of the services delivered that directly relate to the services specified in the approved individual service plan as the services to be provided
- Number of units of the delivered service
- Times the delivered service started and stopped

WAIVER NURSING — 5123-9-39

- Type of service
- Date of service
- Place of service
- Name of individual receiving service
- Medicaid identification number of individual receiving service
- Name of provider
- Provider identifier/contract number
- Written or electronic signature of the person delivering the service or initials of the person delivering the service if a signature and corresponding initials are on file with the provider
- Group size in which the service was provided
- Description and details of the service delivered that directly relate to the services specified in the approved individual service plan as the services to be provided, including the individual's response to each medication, treatment, or procedure performed in accordance with the physician's orders or plan of care
- Begin and end times of the delivered service
- Number of units of the delivered service or continuous amount of uninterrupted time during which the service was provided

ADDITIONAL REQUIREMENTS — WAIVER NURSING

Providers of waiver nursing services shall also maintain a clinical record for each individual which includes:

- Individual's medical history
- Name and national provider identifier number of individual's treating physician
- A copy of all individual service plans in effect when the provider provides services
- A copy of the initial and all subsequent plans of care, specifying the type, frequency, scope, and duration of the waiver nursing services being performed.
 - When waiver nursing services are performed by a licensed practical nurse working at the direction of a registered nurse, the record shall include documentation that the registered nurse has reviewed the plan of care with the licensed practical nurse.
 - The plan of care shall be certified by the treating physician initially and recertified at least annually thereafter, or more frequently if there is a significant change in the individual's condition
- Documentation of verbal orders from the treating physician in accordance with paragraph (E)(6) (E)(8) of this rule
- The clinical notes of an independent provider who is a licensed practical nurse working at the direction of a registered nurse in accordance with paragraph (E)(7) (E)(9) of this rule
- A copy of any advance directives including but not limited to, a "do not resuscitate" order or medical power of attorney, if they exist
- Documentation of drug and food interactions, allergies, and dietary restrictions
- Clinical notes signed and dated by the registered nurse or licensed practical nurse working at the direction of a registered nurse, documenting all communications with the treating physician and other members of the multidisciplinary team

WAIVER NURSING

Providers of waiver nursing services shall maintain, in a confidential manner for at least thirty days at the individual's residence, medication and/or treatment records which indicate the person who prescribed the medication and/or treatment and the date, time, and person who administered the medication and/or treatment

CLINICAL THERAPEUTIC INTERVENTION — 5123-9-41

- Type of service
- Date of service
- Place of service
- Name of individual receiving service
- Medicaid identification number of individual receiving service
- Name of provider
- Provider identifier/contract number
- Written or electronic signature of the person delivering the service, or initials of the person delivering the service if a signature and corresponding initials are on file with the provider
- Description and details of the services delivered that directly relate to the services specified in the approved individual service plan as the services to be provided and details of the individual's response to the services, including progress toward achieving outcomes specified in the individual service plan
- Number of units of the delivered service or continuous amount of uninterrupted time during which the service was provided
- Times the delivered service started and stopped

FUNCTIONAL BEHAVIORAL ASSESSMENT — 5123-9-43

- Type of service
- Date of service
- Place of service
- Name of individual receiving service
- Medicaid identification number of individual receiving service
- Name of provider
- Provider identifier/contract number
- Written or electronic signature of the person delivering the service, or initials of the person delivering the service if a signature and corresponding initials are on file with the provider
- Description and details of the services delivered that directly relate to the services specified in the approved individual service plan as the services to be provided

PARTICIPANT DIRECTED GOODS & SERVICES

5123-9-45

- Paragraph (K) of rule 5123-9-40 of the Administrative Code does not apply to participant-directed goods and services
- Service documentation for participant-directed goods and services shall consist of a written invoice that contains the individual's name and medicaid identification number, a description of the item or service provided, the provider's name, the date the item or service was provided, and the provider's charge for the item or service
- The financial management services entity shall maintain all service documentation for a period of six years from the date of receipt of payment for the service or until an initiated audit is resolved, whichever is longer

PARTICIPANT/FAMILY STABILITY ASSISTANCE 5123-9-46

- Type of service
- Date of service
- Place of service
- Name of individual receiving service
- Medicaid identification number of individual receiving service
- Name of provider
- Provider identifier/contract number
- Written or electronic signature of the person delivering the service, or initials of the person delivering the service if a signature and corresponding initials are on file with the provider
- Description and details of the services delivered that directly relate to the services specified in the approved individual service plan as the services to be provided
- Number of units of the delivered service or continuous amount of uninterrupted time during which the service was provided
- Times the delivered service started and stopped.

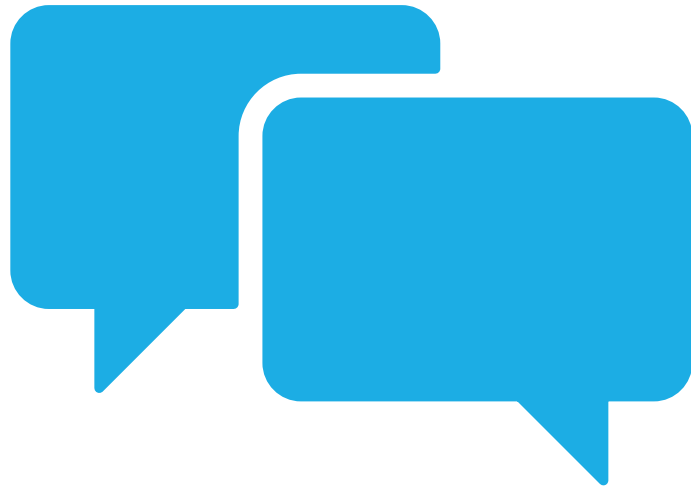
SUPPORT BROKERAGE — 5123-9-47

- Type of service
- Date of service
- Place of service
- Name of individual receiving service
- Medicaid identification number of individual receiving service
- Name of provider
- Provider identifier/contract number
- Written or electronic signature of the person delivering the service, or initials of the person delivering the service if a signature and corresponding initials are on file with the provider
- Description and details of the services delivered that directly relate to the services specified in the approved individual service plan as the services to be provided
- Number of units of the delivered service or continuous amount of uninterrupted time during which the service was provided
- Times the delivered service started and stopped.

COMMUNITY TRANSITION — 5123-9-48

- Type of service
- Date of service
- Name of individual receiving service
- Medicaid identification number of individual receiving service
- Name of provider
- Provider identifier/contract number
- Written or electronic signature of the person delivering the service, or initials of the person delivering the service if a signature and corresponding initials are on file with the provider
- A detailed description of each expense
- A receipt for each expense with the individual's signature, mark, stamp, or other method identified in the individual service plan to verify his or her receipt of the purchased item or service.

STAY UP TO DATE AS REQUIREMENTS CHANGE



Subscribe to DODD
Communications

- New rule notifications
- Memo Mondays
- Important information
- Ohiosp Updates

<https://dodd.ohio.gov/your-family/all-family-resources/Subscribe>

Thursday, May 26

Ohio ISP

Thursday, June 30

Maintaining Compliance

Thursday, July 28

Medication Administration

Thursday, August 25

Billing & Claims

Thursday, September 29

Behavioral Support

Thursday, October 27

UI/MUI

UPCOMING PROVIDER TRAININGS



WWW.DODD.OHIO.GOV/COMPLIANCE OR
WWW.DODD.OHIO.GOV/OSSAS



EMAIL
OSSAS@DODD.OHIO.GOV



CALL 614-466-6670

COMPLIANCE QUESTIONS?

